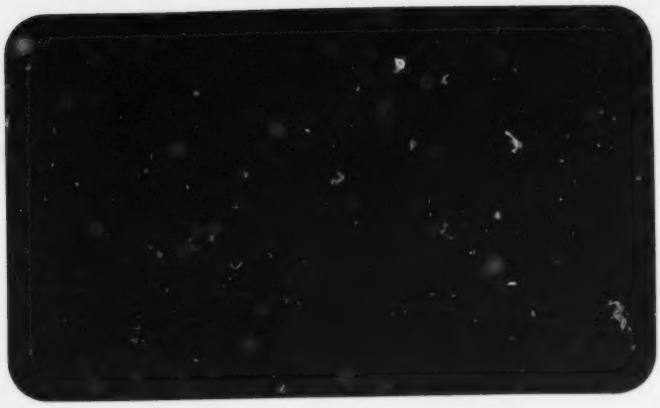

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The Law and the Relationships of Dependency Experienced by Seniors : the case of privately operated homes for the aged

By : Michèle Charpentier

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Ce document est également disponible en français sous le titre *Le droit et les rapports de dépendance vécus par les aînés : le cas des résidences privées pour personnes âgées.*

The Law and the Relationships of Dependency Experienced by Seniors: *the case of privately operated homes for the aged*

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Final Report
Law Commission of Canada

Gerontology and Geriatrics Research Centre
Sherbrooke Geriatric University Institute

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She worked for eight years with seniors and their associations as a social and community worker before devoting herself to research and university teaching.

The Law and the Relationships of Dependency Experienced by Seniors : the case of privately operated homes for the aged

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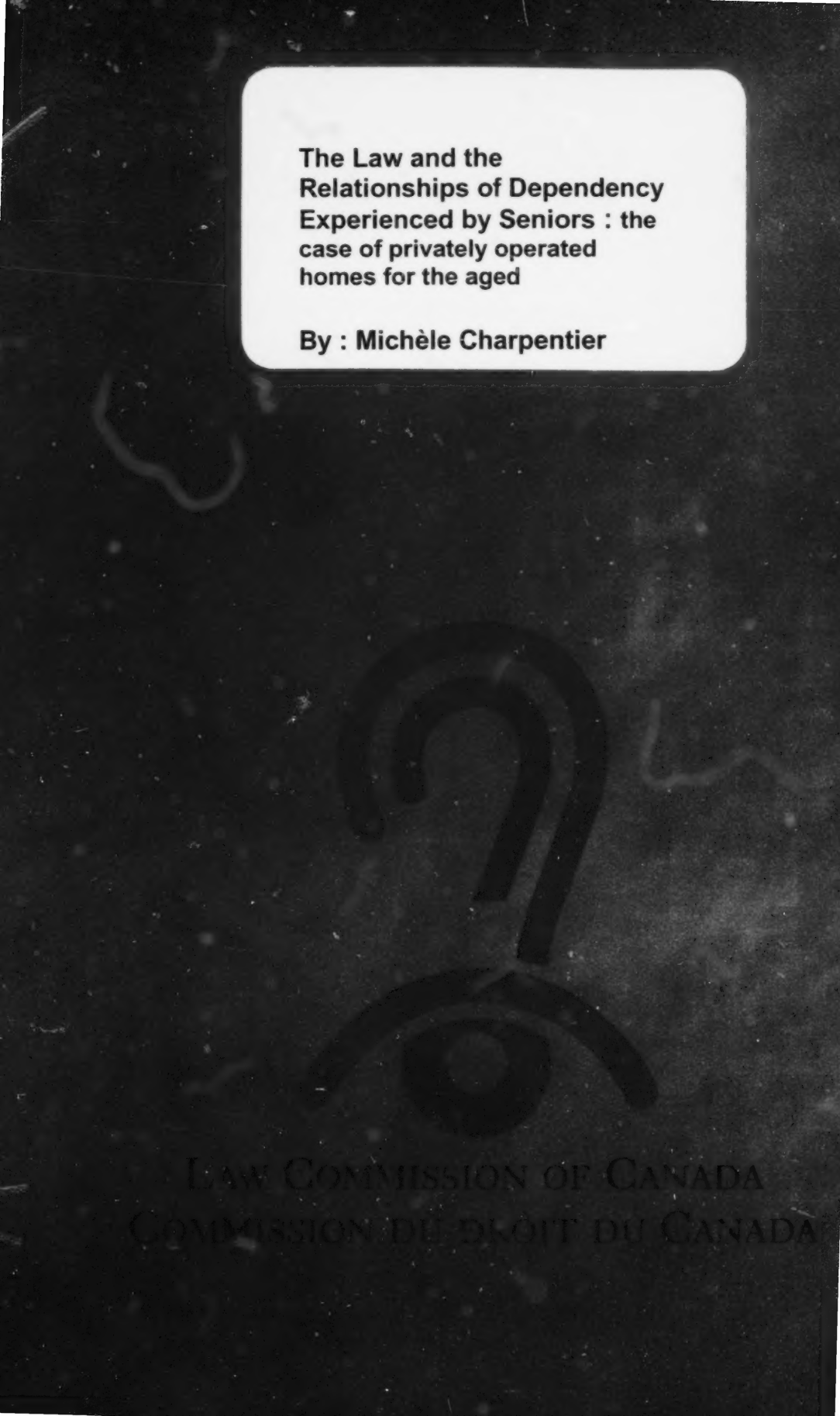

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SUMMARY

This study is about the relationships of dependency experienced by seniors who live in privately operated homes not licensed by the Quebec Ministry of Health and Social Services. Specifically, it provides an analysis of the way in which the law does or does not intervene to regulate these relationships, given the vulnerability of the elderly residents concerned. Does the current law guarantee seniors respect for the fundamental values and principles that underlie private housing, i.e., the freedom to choose their dwelling and to contract, access to quality services and care and protection from abuse and neglect? The study shows there is a discrepancy between the legislative framework in force and the current situation of privately operated homes. These homes have undergone unprecedented expansion and lodge clients who are increasingly dependent because of their old age, their loss of physical and cognitive autonomy, and, at times, their social isolation and financial insecurity. The information gathered also shows major weaknesses in the application and efficacy of the measures of protection, which are based essentially on a complaints procedure.

In order to situate the study in a multidisciplinary and conceptual perspective, a socio-historical analysis of the evolution of private housing and of the changes that have occurred in the health system is presented. The study looks at the concepts of dependency and ageing, applying them to the context of housing. The report also discusses the views of caregivers in the public health system, owners of privately operated homes and senior citizens' associations about the dependency of elderly residents, the values deemed most important and the adequacy of the current framework. Their views point up the importance of rethinking social policies governing vulnerable seniors who live in privately operated homes, and of developing new mechanisms of co-operation between the private and public sectors.

INTRODUCTION

This research report comes within the scope of projects funded by the Law Commission of Canada under the theme of "personal relationships - the elderly." The study is concerned specifically with the relationships of dependency experienced by seniors housed in privately operated homes not licensed by the Ministry.

For the purpose of this report, a private residence is a congregate housing facility of the room and board type (studio, 1½, 2 ½, etc.) which is owned by an individual or body corporate and offers a variety of services (Central Montréal Regional Health and Social Services Board, 1998). A private residence must offer basic accommodation services (lodging, food, supervision) and must not be part of the public system, i.e. accredited. Apartment buildings, low-cost housing, and private facilities holding a licence from the MSSS as a residential and long-term care centre (RLTCC) or recognized as an interim or family type faciity are not included in this definition of a private residence.

This definition therefore covers a wide variety of accommodation facilities, from a single-family dwelling converted to accommodate four elderly people after the children have left, to a luxury urban complex including elevators, a health care unit, a swimming pool, banking services and a hairdresser.

The private housing sector for the elderly has grown dramatically in recent years and acutely points up the problems of the relationships of dependency, even the risk of physical, psychological and financial exploitation, of elderly residents. These residents, because of their old age and the extent of their functional decline, are especially "captive" and vulnerable.

This introduction therefore briefly explains the particular context of the relationships of dependency and interdependency between elderly residents and owners of privately operated homes. It then presents the objectives, content and methodological framework of the study.

- **Context of the study**

For some years, we have seen the expansion in Quebec of a whole private housing sector for seniors. We are referring to the 2,000 privately operated homes not licensed by the Quebec Ministry of Health and Social Services, which house approximately 80,000 elderly residents (MSSS, 1994). These facilities now constitute the main residential resource in Quebec. They are a determining partner and stakeholder in the overall services for the ageing population. If, when they were established, these private resources were aimed at an autonomous or semi-autonomous elderly clientèle who no longer wished to remain at home, a number now accept individuals in significant functional decline, even at the time of admission. This situation is owing to the growing number of elderly, particularly those age 75 or older, with a greater degree of disability (Champagne, 1996), and to the widespread context of budget cutbacks in the public system, and is translating into a desire to reduce the rate of institutionalization. There is no specific law in Quebec governing these private companies and their relationships with users; rather, there are a series of measures derived from various legislation, notably the *Civil Code of Québec*, the *Charter of Human Rights and Freedoms,* the *Act respecting health services and social services* and the *Act respecting the Régie du logement.* We would point out that most institutions are authorized to intervene only when a formal complaint is filed. This is the case, notably, for the regional health boards, which have authority to inspect unlicensed, privately operated homes pursuant to the *Act respecting health services and social services* (R.S.Q., c. S-5, s. 489) and the *Commission des droits de la personne.* The Commission itself may conduct an investigation following complaints of discrimination or exploitation of aged persons and handicapped persons (R.S.Q., c. C-12, s. 10, 48 and 74).

Given the extent of the phenomenon and the vulnerability of the housed clientèles, who are increasingly elderly and dependent, it would seem urgent, in our view, to question the intervention or non-intervention of the law in these "new" relationships of dependency.

- **Objectives**

The purpose of this study is therefore to identify the many relationships of dependency between elderly residents and owners and how the current law affects them. This study also aims to put into perspective the fundamental values and principles that should guide these relationships, and consequently, the intervention of the law.

We therefore wish to stimulate discussion of the adequacy or inadequacy of the law, i.e. whether the current legal framework guarantees to elderly residents respect of the fundamental principles and values of individual freedom, access to health care and services, quality of life and protection that are widely accepted in our society.

- **Content of the study**

This report begins by providing the social and historical context of the development of privately operated housing facilities for the elderly and a brief analysis of the concepts of dependency and ageing. The core of the study is then presented in two parts. The second chapter describes the legal mechanisms that intervene to regulate the relationships between elderly residents and owners of privately operated homes, and analyses their application and protective effect. The third chapter of the study presents the views of the main stakeholders (owners, caregivers and managers in the health system and senior citizens' associations) about the dependency of seniors, the values deemed most important, and the adequacy of the current legal framework. The report concludes by summarizing the main issues raised in this report and identifying some avenues for the future.

- **Methodology**

To complete the study, we first did a survey of the literature and studies on the problem of the dependency of elderly seniors housed in the private sector. The review of the literature covered basic research in sociology, health and social work, as well as research reports and documents produced by the various public and para-public agencies concerned (Commission des droits de la personne, Quebec Ministry of Health and Social Services, etc.). The legal component of the study is based essentially on a search of conventional sources: statutes and regulations, case law and doctrine.

In view of the time allowed to do the research, we favoured a strategy of data collection by focus groups. By means of this qualitative method, it was possible to gather the views of the main stakeholders in a relatively short time. Two separate groups were formed: one of owners made up of privately operated homes, the other made up of managers and caregivers in the health and social services system who work at privately operated homes. For the views of seniors, we used the positions of the groups and associations that represent them, as expressed in reports and opinions submitted to public bodies during consultations. All the participants who were asked to attend a focus group received an invitation along with a brief preliminary document (grid to be filled in) for recording their views and perceptions with regard to:

1. the relationships of dependency between elderly residents and owners of privately operated homes (physical and cognitive dependency, economic and psychosocial dependency);

2. the values and principles considered most important in the context of private housing and that should govern relationships of dependency;

3. the capacity of existing measures to ensure and guarantee respect for the values and principles identified (adequacy and inadequacy of the current framework).

The interviews were recorded to make it easier to analyse the content, care being taken not to link the ideas expressed to the individuals. The information gathered was classified according to the three topics broached. The essential points of the comments analysed are reported in the third chapter.

We would like to extend our sincere and warm thanks to those individuals who agreed to participate in these focus groups. Their contribution and thoughts were abundantly helpful.

1. CONTEXT

We thought it would be helpful and relevant, before analysing the relationships of dependency experienced by seniors living in privately operated homes, to place them in a social, historical and ideological context. The first part of this chapter presents the social and political context of the evolution of the private lodging sector for seniors. This evolution is closely linked to the profound transformations that have marked our health system and our social policies on the ageing population since the 1960s. The second part of this chapter is more theoretical and is intended to present and define the concepts of dependency and ageing underlying this study.

We wish to remind readers that our study concerns exclusively senior citizens living in privately operated residential facilities. This bias may help reinforce the image of an old age of nothing but declining autonomy, and feed the even more widespread preconception that most old people live in residential institutions. We therefore feel it is important to point out *a priori* that the historical and current life situations of seniors are heterogeneous, that growing older is not synonymous with decline and does not lead inevitably to the home for the aged, the lodge or the privately run residence.

1.1 The evolution of privately operated homes for the aged

1.1.1 1960 to 1980: the trend towards institutionalization

The 1950s and 1960s marked the start of the age of the Welfare State. A wind of claiming responsibility blew in favour of greater government involvement in battling social problems. Our society thus shifted from an ideology of private, and mostly Christian, charity to an ideology of "welfare." The traditional family underwent profound change: the number of children per family dropped considerably and divorce appeared as a new reality. A result of better living conditions, scientific advances and access to hospital services, life expectancy rose significantly. There

was a new sensitivity among the population of the fate that awaited the elderly. Senior citizens had become a recognized social group and their standard of living would mobilize a number of debates about the social policies and measures that should be adopted (Snell, 1996). In 1949, the federal government had created a Senate committee on the status of senior citizens, which advocated a universal program of old age benefits.[1] The universal system set up in the early 1950s was directed at the elderly age 70 or older, but the eligibility age would gradually be lowered to age 65 in 1970. The old age pension was no longer an act of charity, of helping the most needy, but a social entitlement for the elderly. In this new context, in which the "problem" of ageing was managed collectively and impersonally, there was no longer the same economic obligation to "look after and take in" ones elderly parents, as in the past (Drulhe, 1981:6). Next came the creation of public institutions to take in and house pensioners, with their many practitioners (social workers, nursing staff, specialized educators, physiotherapists, etc.).

In Quebec, the expansion of a strong public lodging sector was in keeping with the extensive reform of health and social services initiated by the Castonguay-Nepveu Commission (1966-1972), which would generate a "veritable network" of institutions. Thus, from the 1960s to the early 1980s, many lodges and nursing homes were built in Quebec and the government bought up most of the hospices and asylums owned by the religious communities. The Quebec State would adopt, moreover, a moratorium to block the development of privately operated, for-profit homes (Vaillancourt, 1997:158). The new public and private government-regulated residential facilities would represent a total of 60,000 beds (Rochon, 1988:218). There was a withdrawal of commitment on the part of families that increasingly "placed" their elderly parents. It might be said there was a break with the previous period to the extent that there was a dequalification of family care in favour of greater specialization and professionalization of care. It is worth noting that this

[1] The first act respecting old age pensions (1927) would allocate only a small allowance to very needy persons age 70 or older who were living in considerable poverty. We might point out that Quebec had refused to take part until 1936 for political and ideological reasons given its attachment to the liberal values that valued family and private acts of charity.

"massive" institutionalization also affected relatively autonomous individuals. Some readers will undoubtedly recall a time when the elderly entered nursing homes with suitcase in hand! Each institution was autonomous with respect to its admission policy, and some were reluctant to admit confused or senile clients.

> [Translation]
>
> In the 1960s and early 1970s, it was usual for an elderly person to aspire to spend his days in a home where not only would basic services be available and security assured, but there would be stimulating socio-cultural activities. This was the ideal model.... (Rochon, 1988:220)

But institutionalization also means depersonalization and homogenization. Gradually, a change took place in the philosophy of care. There was concern that elderly people would be abandoned in institutions, and it was thought that the quality of life and autonomy would improve, as would the health of public finances, if the senior citizen remained at home longer. From 1975 on, the system of admission to a nursing home was regionalized and access limited to the most needy clientèles, evaluated using the grid for Classification by Types of Programs in Extended Care and Service Facilities, and labelled "A-3, A-4." Medical diagnosis substituted for social diagnosis.

The next period, which we are experiencing today, was being readied—that of de-institutionalization and home support (first policy published in 1979), which once again is based on the family and leading to the parallel development of privately operated homes for the aged. Table 1, below, summarizes the main elements of the social context, the perception of ageing and the spread of residential facilities during this period characterized by the institutionalization of the elderly.

TABLE 1

The trend towards institutionalization

social context	• Questioning of liberal ideology • changing society: ↓number of children/family, ↓ power of the clergy, start of divorces, social mvmt of women and elderly • intervention of federal, then provincial, government in areas of health, soc. serv. and education / social safety net • social-democratic ideology • **age of the Welfare State**: government regulation of services and institutions
Realities/ Perceptions Of ageing	• ↑ life expectancy: owing to better living conditions, scientific advances and access to hosp. Services • sensitivity to fate of the elderly, who now constitute a social group • universality of old age benefits '50: pension no longer an act of charity, but an entitlement - socio-econ. impacts • growing reliance on placement • founding of the FADOC (1970), then the AQDR (1979) • **ageing, socially recognized, is "managed" collectively and impersonally**
Residential facilities	• State buys up asylums and hospices • construction of lodges and nursing homes / strong public lodging sector, which will total 60,000 beds • specialization, profess. and medicalization of services for the elderly • admission of autonomous elderly clientèles-lodges and nursing homes • moratorium on develop. of privately operated, for-profit homes for the aged • gradual change in philosophy of care - regional system of admission to lodges and nursing homes in 1975 (Classification by Types of Programs in Extended Care and Service Facilities, A-3, A-4!) • **the nursing home: public facility that institutionalizes, homogenizes and depersonalizes the elderly**

1.1.2 1980 to the present: home support, de-institutionalization and the upsurge in privatization

The early 1980s were directly linked to the economic crisis. But aside from the thorny issue of public finance, it was the legitimacy of the State and its management model that were at stake. The universality of social programs was in question; several protective measures were affected; the health, care and lodging system was central to the debates. It was expensive! Institutionalization, medicalization and "technicalization" were questioned. The State appealed more to individual responsibility (neo-liberal trend) and family and community solidarity (socio-community trend). Keeping dependent individuals in their home environment was a main objective. In this context, in which the State sought to reduce its public health expenditures and lower its rate of institutionalization, despite the growing ranks of the very elderly, another type of housing facility abounded: privately operated homes.

Quebec, like all industrialized societies, was seeing an accelerated ageing of its population. While persons age 65 or older represented 6.7% of the Quebec population in 1941, they now made up over 12%, to reach 20% in 2031 (Champagne, 1996). If it had been clearly shown that a greater life expectancy is not accompanied by a comparable longer disability-free life expectancy, the observation that a growing number of very elderly citizens were grappling with physical and cognitive disabilities was mobilizing all social, economic and scientific attention. The new discourse centred on the social and economic costs generated by an ageing population was somewhat alarming, excessive. There was less and less talk about the elderly, their contribution to a more humane and united society, and more and more about old people who were becoming less functional and more dependent. Ageing, now socially recognized, was defined almost solely as a problem, even an illness—the illness of dependency (Dherby, Pitaud et al.,1996; Drulhe, 1981). This obsession with autonomy (with its loss) is no stranger to another: the obsession with the zero deficit.

The health system was facing a real transformation: the merger and disappearance of certain types of institutions, rationalization, decentralization-regionalization, de-institutionalization/home support, and just recently, the trend towards more ambulatory care. Reports and policy statements followed one after the other, the most decisive being the Rochon Commission (1986-88 commission of inquiry on health services and social services) and the Côté Reform (1990). Specifically with respect to lodging, there was a radical about face. Lodges and nursing homes were first merged, then eliminated to become residential and long-term care centres organized more along the lines of hospitals. The residential institution became cumbersome and less and less accessible; it was reserved for the most sick and dependent. Actually, to be admitted to a residential and long-term care centre, a senior had to require close to 3.5 "care-hours" a day, according to the jargon. Local community service centres (LCSC), the establishment and expansion of which was slowed, were confirmed in their mission of providing home support to individuals of declining autonomy, particularly the elderly. However, while the budget allocated for homecare services increased considerably, services remained inadequate. The family and community service and volunteer groups were increasingly relied on. Women became "natural helpers," and again the burden of helping and caring for their elderly parents and close dependants rested on them (Garant and Bolduc, 1989; Guberman, Maheu and Maillé, 1991). Thus, at a time when the need for services for the very elderly and those of declining autonomy was growing, access to residential institutions was limited, and the lack of home support services and the exhaustion of families was being felt. Then came an upsurge in the privatization of residential facilities unprecedented in our history of health services in Quebec. The conditions were ripe for the rapid expansion of a market sector in lodging: neo-liberal ideology combined with a discrepancy between the public demand for and supply of services. Thus, with the "unofficial complicity" of governments, there was a phenomenal increase in the number of privately operated, for-profit homes (Brissette, 1992; Vaillancourt, 1997). In fact, the number of places in private residences has now reached 80,000 (Vaillancourt, 1997:169) while the numbers in the public system continue to drop. In 1995, the

socio-sanitary accommodation system (i.e. accredited) comprised 51,000 places compared to a total of 60,000 beds in the '70. The private system became the principal actor in housing for seniors in Quebec. It thus took over where lodging for seniors, once controlled by publicly operated homes, had left off.

In 1994, the Quebec Ministry of Health and Social Services (MSSS) would compile a record of privately operated, unlicensed homes that provides a general profile of this sector. According to the Ministry's record, homes with fewer than 10 residents accounted for 50% of privately operated facilities. However, these small family-type homes housed just 9% of the clientèle, while homes with 100 or more residents housed over 50% of the clientèle. It emerges that homes with 30 or fewer residents represented nearly 75% of privately operated homes and took in 20% of the clientèle. It can be seen that from that point on, the single term "privately operated homes" included facilities of widely differing structures. Some belonged to a more family- or community-based model, and others to a more business-like model ranging in size from medium to large with a number of shareholders. Three quarters of these homes, all categories combined, reported providing the following services: care and support services (to meet basic needs), supervision and security, food services and nursing care or visits by a physician. Table 2 shows the main features of this period in terms of social context, perceptions about ageing and the evolution of residential facilities.

TABLE 2

Home support, de-institutionalization and the upsurge in privatization

social context	• public finance crisis and the State management model • questioning of the universality of social programs • trend towards de-institutionalization and demedicalization • valuing of volunteerism, community and family • neo-liberal ideology and socio-community trend • **age of State decommitment**
realities/ perceptions of ageing	• explosion of the elderly population (the seniors boom) • new discourse centred on declining autonomy, dependency • ↑ research in geriatrics and gerontology, creation of first diplomas in gerontology • **ageing is a social issue increasingly defined as a problem ... the problem of dependency**
lodging resources	• budget cuts in the health system and merging of institutions. • abolition of lodges and nursing homes, replaced by residential and long-term care centres (clientèle requiring considerable care) • public residential institutions are less accessible to the elderly • ↑ role of the family ("natural helpers," trend towards more ambulatory care) • upsurge in privatization, rapid expansion of market sector in lodging / over 2,000 privately operated homes for the aged, + 75,000 residents • recognition of need to develop new resources – RI, RTF, State or socio-community type partnership? • **home for the aged: a privately operated, for-profit facility that is rapidly expanding, accounting for 2/3 of lodging**

In view of the expansion of the market sector in lodging for the elderly and the range of services it provides, there is reason to question the legal framework governing these privately operated businesses in their relations with their elderly residents, particularly those of declining autonomy. But before analysing the intervention of the law, in the next section we present an updated look at the concepts of ageing and dependency inherent in this study.

1.2 The concepts of ageing and dependency

1.2.1 The ageing of the population

As we just pointed out, the ageing of the population is a distinctive phenomenon of industrialized societies. In 50 years, the percentage of elderly people in the Quebec population has nearly doubled, to its current level of 12%. This change in the age structure generally associated with increased life expectancy is owing primarily to the decline in the birth rate. It is accompanied by two inordinately important phenomena which we will present a little later: the internal ageing of the elderly population, and its feminization.

To illustrate the overall ageing of the population, demographers use what is called the "age pyramid." This is a graph showing the population distribution by age and sex; age is shown on the y-axis, and the number of individuals is shown on the x-axis (on the left - males, and on the right - females). Thus, we have gone from a pyramid in the shape of a triangle characterized by a high birth rate and a progressive death rate, to a pyramid in the shape of the ace of spades. This latter pyramid is typical of a society such as ours where the birth rate is low and the death rate is at older ages. The ageing of the population can also be seen in the significant increase in the median age and the increase in the so-called dependency ratio (that is, the number of persons age 65 or older over the number of persons age 20 to 64). The dependency ratio, corresponding to .14 in 1951, rises to .21 in 2001, and is estimated at .42 in 1936 (Desjardins and Dumas, 1993:13). All these demographic data have largely fuelled the debate surrounding the social, economic and political consequences of an ageing society. They also

help increase the fears that the growth in the number of elderly in the population is causing a dramatic increase in long-term health and care costs. Without a doubt there will be considerable pressure on public and private pension plans in future, particularly when the large baby-boom generation reaches retirement age. Special challenges arise also in terms of the organization of services and the development of resources to meet the new needs of the growing number of elderly, particularly as the number of children per family is declining and these children are more widely dispersed geographically. But the discourse has assumed an almost alarmist tone, linking at once ageing, decrepitude and dependency.

> [Translation]
>
> Without minimizing the effects of the demographic change, we cannot confine ourselves to this *naturalistic* analysis, whereby a mechanical evolution of needs would follow the demographic increase combined with the change in health status of successive generations of old people. (Attias-Donfut, 1997:15)

It is not because someone reaches age 65 or 72 that he becomes a dependent citizen! According to the information from the 1992-93 health and social survey, a man and a woman reaching age 65 can expect to live another 15.5 and 20.1 years, respectively, most of them with no loss of autonomy. It is only in the last years of life (that is, 4 years for men and 7 for women) that they will have to cope with a loss of autonomy ranging from slight to very considerable (Enquête sociale et de la santé, 1995: 298).

A description of the ageing of the population cannot, then, be limited to a presentation of the number of elderly in the total population. It must take into account the size of this population by sex, the different age groups comprising it, and their differential characteristics. The notion of the internal ageing of the elderly population refers to the significant increase in the number of very elderly citizens within the cohort. The percentage of people age 75 or older, which remained fairly stable until 1960, has climbed to 45%, now making up nearly half the population age 65 or older. In 2036, those age 75 or older will account for 12% of the total population and the number of very old (age 85 or older) will have grown by a factor

of 24 since 1951 (Desjardins and Dumas, 1993:14). Seen along with this ageing of the older population is the phenomenon of feminization. As the population ages, it becomes more feminized because of the greater life expectancy of women. The masculinity ratio, that is, the number of men per 100 women, is currently 67 at age 65 or older and 53 at age 75 or older (Charpentier, 1995). Old age therefore does not occur in the same way for women and men; it is not experienced in the same way at age 66 as at age 92. Colloquially, the term "old old" is used to refer to the reality of people age 75 or older, and to differentiate it from that of the "young old," who are age 65 to 74. It is the old old, mostly women, who have more physical and cognitive disabilities and are more inclined to have to rely in their later years on residential facilities.

The next section concerns specifically the notion of the vulnerability and dependency of seniors in the context of lodging.

1.2.2 The concept of dependency

Thus far, our comments have attempted to show how the concept of dependency has evolved socially and how it is closely associated with the phenomenon of ageing. Increasing use is made today of the concept of autonomy, or its opposite, dependency, to distinguish between a more positive image of the "young old," active retirees, and that of the "pathological" ageing of the demented and the elderly of declining autonomy.

> [Translation]
>
> The definition of a dependent elderly person today receives broad consensus: it is someone able to perform the basic acts of everyday life without the assistance of a third party, and who, because of their age, comes under social old-age programs. This definition places it at the crossroads of the universe of the practices and social models legitimized by medical discourse, and the institutional universe in which the relationship of dependency is established. (Attias-Donfut, 1997: 15)

Dependency implies, then, a helping relationship, a system of support, and exists through the caring and helping practices, mainly institutional, that established it. The conceptual framework of dependency is therefore largely occupied by the

medico-hospital apparatus, and increasingly by the community sector, the family and the private lodging sector, as we showed in our brief historical overview. Dependency cannot, however, be limited to the physical dimension and to the need for help with everyday activities. In his many studies of dependency, professor emeritus Albert Memmi extends the notion of dependency to any constraining relationship (more or less accepted) based on the meeting of a need or desire (1979, 1997:11).

> [Translation]
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> Let us say briefly that dependency is the need or desire for others, to which corresponds a greater or lesser system of support; a system of support being that which meets the expectation of the dependent.

Our life is thus woven out of a series of varied, and more or less satisfying, dependencies (emotional, material, financial, instrumental, etc.) which break down and are replaced by new systems of support. A separation, job loss are definite ordeals in life, but we generally manage to rebuild new bonds, to develop new systems of support. But as we get older, the social system erodes and is difficult to replace. Ageing is characterized by an "increased scarcity of substitutes." Old age appears as "a series of gradual, cumulative, and above all, irreversible breakdowns of support systems" (Memmi, 1997:12). The elderly, especially the very elderly, face a paradox: it is at the time when their physical and psychological autonomy is diminishing that they face a decline, even a loss, of their usual systems of support. The dependency of old people is therefore not only physical, but psychological and social as well. There is a certain disengagement of the older person who experiences several losses of social actors (caregivers, relatives, spouse, etc.), but also a disengagement of society from them. Despite the involvement of close relations and family, the isolation of the elderly is a reality that causes concern.

1.2.3 The dependency of seniors living in privately operated homes

It will be understood from the foregoing that the broader the support system, the greater the dependency of the elderly person. In the context of privately operated residential facilities, the home tends to provide for a number of needs of the elderly: lodging, meals, daily assistance (washing, dressing, recreation) and even care (medication, pressure ulcers, etc.). Sometimes, the home will also provide material assistance with shopping and assets management. While we must constantly take others into account, even several others (family, spouse, employer, owner, etc.), the everyday life of elderly residents virtually depends on a single support system: the residential facility, personified by the owner. The relationship that is established between the resident and the owner reaches a very high level of dependency that is especially worrisome as the relationship exists 24 hours a day, 365 days a year, and often for several years. Of course, not all elderly residents experience such intense relationships of dependency; some manage to maintain control over their fate and exercise their basic freedoms. Also, we must not lose from sight the fact that residential facilities, whether private or public, are intended to provide the elderly with a quality living environment, security and basic care. However, by their very structure and culture, they risk generating psychological and social breakdown, thereby increasing isolation, and consequently, the dependency of residents. "Now, dependency is often an opportunity for subjection: the giver believes they have entitlements." (Memmi, 1997: 13). The step from dependency to dominance is easy to take, especially when the elderly person is weakened by social isolation and loss of physical and cognitive autonomy. Recent studies profiling the elderly living in privately operated homes tend to show that they constitute a particularly vulnerable clientèle.

In 1996, a team from the Research Centre of the Sherbrooke Geriatric University Institute did a study of the quality of care provided to seniors of declining autonomy by licensed and unlicensed residential facilities in the Eastern Townships (Bravo, Charpentier et al., 1997). The purpose of this study was to evaluate and compare the quality of care and services provided to seniors of declining autonomy by the

two lodging networks (301 subjects, 88 residential facilities), as well as to provide a detailed profile of their respective clientèles and managers. The residential facilities, chosen at random, were from urban and rural areas in Estrie, a region that mirrors fairly closely the bicultural reality of Quebec. From the study data, it can be estimated that 64% of the clientèle housed in privately operated, unlicensed facilities are losing their functionality. The socio-demographic profile of these residents, also randomly selected in both sectors, proved quite comparable; the average age was 84, two thirds were women, widowed and had less than 8 years of schooling (Bravo et al., 1998:146). Among the clientèle of declining autonomy in the unlicensed sector, a significant proportion presented with considerable cognitive impairment (39% had a 3MS score below 60) and significant functional disabilities (17% had a FAMS score below 40/87). The largest proportion of seriously impaired cases was found in the small (fewer than 9 residents) and medium-sized homes (10 to 39 residents); 54.2% and 49.8% of them, respectively, had very significant cognitive deficits. The degree of impairment of this clientèle is all the more worrisome as 44% of owners straightaway reported keeping on a resident whose condition had become too serious for their resources—a proportion that climbs to nearly 60% in the small homes (1998:147). As for the characteristics of owners of privately operated homes, they reveal their lack of special training and experience in caring for frail seniors. Also, few take on qualified staff, even on a casual basis (26%).

> One of the major findings from our study concerns the training and experience of the managers of the unlicensed homes: 31.9% admitted having no training and 58.8% said they had no previous experience in caring for dependant elderly people at the time of hire. These data are even more disquieting given that a significant proportion of the residents had severe cognitive deficits or a substantial loss of autonomy, especially those in the small unlicensed homes. (1998: 148)

Though disturbing, this profile of the current reality is intended mainly to illustrate the increasingly decisive role of the private sector in providing lodging, care and services to the very elderly of declining autonomy. Many of these elderly can no

longer be kept at home and do not want, or are not sufficiently "handicapped," to be admitted into public-sector nursing homes. The intention here is not to start a witch hunt; it is therefore important to point out that the majority of managers are attached to their residents and concerned for their welfare. Because of its diversity, its local and regional colour, its ability to house couples, the private system has considerable appeal. As for the quality of the care it provides, the study by the Sherbrooke Geriatric University Institute shows that the overall quality ratings are quite good, and even comparable to those of licensed residential facilities (Bravo et al., 1997:34). But the averages hide discrepancies, and we cannot fail to mention that 15-23% of residents in the unlicensed sector receive care that is considered inadequate, with the highest percentages being in the small homes (:37-38). The 1997-1998 report on complaints handled by the Régie régionale de Montréal-Centre clearly shows the diversity of situations and the problem of inadequate care.

> [Translation]
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> As we stated last year, the reality surrounding these situations may include a variety of possibilities between two extremes. At one extreme, we see facilities aware of their limitations and doing their best to provide adequate assistance to people whose condition has deteriorated and who refuse to leave a facility to which they have become attached. At the other extreme, there are those facilities where the person who has lost considerable autonomy, often confused and isolated, easily becomes the object of abuse and neglect. These individuals may not be properly fed, their hygiene may be neglected, they move about less and less and develop more serious health problems: dehydration, confusion, falls, pressure ulcers, incontinence, and so on. A number of situations of individuals requiring three or more hours of care a day were brought to our attention again this year. (RRSSSMC, 1998: 145)

This is where special attention is required within the legal framework governing the "new" relationships between owners and residents, given the factors of vulnerability we have just presented (physical, cognitive, economic and psychosocial dependency of current clientèles). What mechanisms are in place to

ensure the protection of vulnerable residents and guarantee them a quality living environment where they will be treated well and receive the necessary assistance and care? We attempt to answer this question in the next chapter.

2. DESCRIPTION AND ANALYSIS OF THE LEGAL MECHANISMS GOVERNING THE RELATIONSHIPS BETWEEN ELDERLY RESIDENTS AND OWNERS OF PRIVATELY OPERATED HOMES

Over the past fifteen years or so, the health and social services system has been undergoing profound changes that affect the whole of its organization and provision of care. These changes, very much guided by economic considerations, are characterized by a withdrawal of certain services assumed by the State and a transfer of responsibilities to other social agents: the family, the community network and the private market. As a result, a whole debate has arisen about the effects of these new strategies. The studies to date have been concerned primarily with the increased role of the family (Lesemann and Martin, 1993; McDaniel and Gee, 1993) and the community sector (Skelton, 1998; Shragge, 1998; Salomon, 1995; White, 1994) in the context of a pluralist society. Few studies have looked at the privatization of housing services for seniors (Vaillancourt, 1997; Vézina et al., 1994). We feel it is helpful, if not urgent, to analyse the current measures governing privately operated homes in Quebec in view of the vulnerability and increased dependency of their ageing clientèles.

This chapter therefore describes and analyses the legal framework that intervenes to regulate the relationships between elderly residents and owners of privately operated homes. It questions the degree of protection accorded to seniors from the main risks—health, economic and psychosocial—to which they are exposed. To this end, we first identify the descriptive, evaluative and comparative studies on private homes for the aged (Bravo, Charpentier et al., 1997-1999; Castle, 1998; Dubois, 1998; Aaronson et al., 1994; Vézina et al., 1994; Ullmann, 1987). The analysis of the Quebec framework of intervention is based on ministerial documents and reports of the main agencies concerned (Quebec Ministry of Health and Social Services, 1994-1995; regional health and social services

boards, 1994-1998; Commission des droits de la personne, 1992-1983; Corporation professionnelle des travailleurs sociaux, 1992; Société d'habitation du Québec, 1992-1993). Finally, we examine the various legislative provisions and court rulings regarding their application.[2] The legal mechanisms are presented and analysed according to underlying fundamental principles, namely: the principle of freedom to choose one's dwelling and freedom to contract, the right of access to quality health services and care, and finally, protection from all forms of abuse and neglect.

2.1 Freedom to choose one's dwelling and freedom to contract

Homes for the aged are private, usually for-profit, businesses that belong to the commercial lodging sector. While the free market and competition operate in the case of shopping for and buying a refrigerator, the situation is entirely different when it comes to choosing a living environment (Latimer, 1997-1998). This is a matter of determining where an often very elderly person, and one, moreover, of declining autonomy, will live 24 hours a day for some years. This entire system is based on the notion of the individual's freedom of choice and freedom to contract. Is it possible to speak of free and informed choice in the context of lodging? How do these market forces operate when the consumers are elderly people of declining autonomy?

This section will present the few measures that regulate these business relationships between entrepreneurs and elderly consumers and discuss their consequences for the most vulnerable residents. Private matters of public concern!

[2] The reader may consult the list of legislation and case law studied in the References section.

2.1.1 Description of the legislative measures provided by the *Civil Code of Québec* and the *Act respecting the Régie du logement*

The relationships between owners and residents are governed by the general provisions of the *Civil Code of Québec* with respect to contracts, leasing, and specifically leases of dwellings (C.C., art.1892 to 1978). Of the 3,168 articles of the *Civil Code,* just one concerns specifically the lodging of the elderly or handicapped. This article allows for the termination of a lease when the elderly tenant "is admitted permanently to a residential and long-term care centre or to a foster home" (C.C., art.1974).[3] Other than specific provision, the usual rules regarding leasing apply to privately operated homes. On entering into an agreement, the owner-landlord must complete the mandatory lease and provide the tenant with a copy.[4] When additional services are offered because of the tenant's age or disability, a schedule must be added to the lease. This schedule contains a detailed description of the fitting out of the dwelling (grab bars, call bells, etc.) and a list of services that may be provided: laundry, housekeeping, transportation, recreation, distribution of medication, and even nursing and personal care services. For each service offered, the owner must specify whether it is included in the rent or state the additional fee (fixed monthly amount or fee per service). The law, however, permits the verbal lease, which is much more common.

We might point out that owners are completely free to set their rates,[5] while tenants have the freedom to refuse or to compel the owner to appear before the Régie du logement to justify the price asked. The Régie intervenes in any owner-tenant dispute referred to it and serves as a tribunal.[6] Now, the elderly, particularly

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[3] . As the Act does not define the notion of "foyer d'hébergement" (foster homes), some rulings concluded that the definition included privately operated homes, while others did their best to distinguish between "foyers privés," "foyers d'hébergement" and "résidences privées." In this regard, see *Les résidences de Longpré inc. c Marie-Josée Fortier* [1998] R.J.Q. 3305, *Desjardins c Gianchetti* C.Q. Laval 540-02-002254-952, 1996-09-30, J.E. 96-2103 (10p), *Rose Kwavnick c Les résidences Caldwell* [1995] R.J.Q. 265.

[4] See *Règlement sur les formulaires de bail obligatoires et sur les mentions de l'avis au nouveau locataire,* D.907-96,(1996) 128 G.O. II,4855

[5] The reader will understand that the owner will have to adjust his prices to the laws of the marketplace if he wants to ensure a good room occupancy rate. However, this regulation of prices by the marketplace plays a role primarily in the recruitment of new residents. Current tenants constitute a particularly captive clientèle.

[6] The Régie is constituted by virtue of the *Act respecting the Régie du logement*, R.S.Q., c.R-8.1 and has exclusive jurisdiction over rental housing when the amounts sought are less than $15,000. We might point out that part of its activity is devoted to providing information and preventing conflicts between landlords and

the old old, have limited resources and are somewhat disinclined to use the recourses, particularly when they are subject to judicial control. This measure to protect tenants therefore seems more theoretical in the context of leasing a private lodging service. We thus find ourselves in a system of almost absolute freedom to contract. There is, then, good reason to question the limits and consequences of this freedom given the weakness of the measures that frame its exercise and the vulnerability of the elderly contracting parties.

We should acknowledge *a priori* that the right of freedom enshrined in our Charters is one of the fundamental values of our society. This right implies the freedom to come and go and entails, notably, the right to choose one's domicile and one's dwelling (White, 1986:22). Unlike the situation that prevails in public institutions, the choice of one's future environment and way of life prevails in the private sector.[7] Moreover, in the private sector, most residents occupy a single room or cohabit with someone of their choice, usually their spouse (Bravo, Charpentier et al., 1997:25). This is an advantage that influences the decision to choose a privately operated home. However, numerous constraints are placed on residents' freedom to contract and even, in extreme cases, compromise the validity of the lease agreement. We will see that the exercise of free and informed choice, a condition on which the validity of a contract is based in civil law, is far from assured.

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tenants. It offers, notably, a conciliation service.

[7] In the public system, it is far from evident that the bed available will be in the resident's institution of preference.

2.1.2 Analysis of the application and effects of the measures

First of all, the circumstances that prompt the resort to placement are often difficult and sudden: death of a spouse, stroke, hospitalization, and so on. The search for a proper facility usually encounters the difficulty of access to information about privately operated homes, their services and fee structure. While most public institutions have a list of the privately operated facilities within their territory, caregivers are reluctant to suggest a specific home—a reservation or defensive practice which is scarcely surprising given the lack of control over the quality of the care provided. In its opinion on the use of unlicensed facilities, the Corporation professionnelle des travailleurs sociaux (1992) recommends that its members not refer to these facilities clients who present with cognitive deficits and are isolated. But the practices and policies vary from person to person, institution to institution.[8] In view of the lack of information and references, more and more people are turning to placement agencies. Private, lucrative businesses have sprung up in the wake of the privatization of the lodging sector. It seems, then, that the elderly do not have the necessary tools to exercise informed choice.

As a large percentage of elderly people living in privately run homes have cognitive limitations, it is in fact their children who choose their living environment and negotiate on their behalf. Most incapable seniors do not have the benefit of a system of protection, which makes them especially vulnerable. Some very isolated people do not even have close relations or a family member to manage their affairs.[9] Sometimes, it is the owners of the facility themselves who manage the financial affairs of their residents or accept gifts and loans of money (RRSSSMC, 1999: 145). These situations of conflict of interest may very well degenerate into financial abuse.[10]

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[8] Some system actors (managers, professionnels, caregivers) themselves own private residential facilities. This may be perceived favourably from a standpoint of quality and competence, but does rais some questions about possible conflicts of interest.

[9] While acknowledging this is an important social issue itself worthy of attention, our analysis will not touch on the question of the representation of incapable persons of legal age or on the mechanisms for opening up systems of protection provided by the *Civil Code* and the *Act respecting the Public Curator*.

[10] The newspapers recently reported the sentencing to two years in prison of an owner who had plotted to convince an elderly resident at his centre to give him power of attorney and name him legatee of her assets. " Deux ans à un ex-proprio de foyer » *La tribune,* 18 March 1998. The Brzozowski case is another instance of

The financial status of residents is another major limitation on the freedom to choose a privately operated home. According to our knowledge of the market, the basic cost of room and board ranges from $750 to over $1,500 per month. As for the rates for additional care and services, they fluctuate considerably. Now, the current retirement and old age security policies guarantee seniors rather modest replacement earnings. According to the National Council of Welfare (1995), the poverty rate for seniors rose to 47.2% for women and 32% for men. The situation of those with no old age pension or guaranteed income supplement, mostly women, is especially precarious. On a monthly income of $899, how can an elderly woman with severe osteoarthritis afford room, board and the additional services required by her condition (help with bathing, getting up and dressing, etc.)?

Based on the study by the Geriatric University Institute referred to earlier, it can be estimated that 52% of residents of declining autonomy in unlicensed homes are living on just the old age pension and guaranteed income supplement (Bravo et al., 1997:24). The analyses confirm a relation between the income of residents and the quality of the care they receive. The effect of the source of income on the quality rating suggests that the more affluent residents are better able to obtain quality care or that the home tends to serve them better (:42). The financial insecurity, even poverty, of residents, especially female residents, is a real issue that extends well beyond the private realm.

> With regard to the aged, evidence for the interrelationships between private and public abounds. For example, poor health is related with gender (Gee & Kimball, 1987). A future to recognize the "public" component of problems of individuals sets the stage for the creation of an elderly underclass, mostly comprising women, who are blamed as individuals for the play of social and economic forces that underlies their dependency. (Gee, 1995)

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financial exploitation, this time involving elderly immigrants. *Commission des droits de la personne du Québec c Brzozowski* [1994] R.J.Q. 1447.

While a number of owners are sensitive to this problem and attempt to make accommodations, they cannot unduly absorb the costs associated with the dependency of their less affluent residents. Let us remember that 75% of the homes accommodate fewer than 30 residents, which means they themselves are in a financially weak position. Sales, closures and bankruptcies are numerous. This volatility has enormous repercussions on residents and is the source of a lot of insecurity.

Despite all these limitations on the exercise of the free and informed choice of a privately operated home, despite the vulnerability of many of the seniors concerned, the system of individual freedom to contract prevails without arousing debate about the judiciousness of developing protective measures. The law of the marketplace, which has always maintained, even increased, social inequalities, is, in the context of private lodging for the elderly, reaching its crisis point. This analysis of the consequences of this "unrestrained" laissez-faire theory is prompting a re-emergence of the need for social protection to guarantee for the least affluent elderly the security and services essential for their well-being. It is in this context that the measures for guaranteeing residents access to quality care and services assume their full importance.

2.2 Access to quality services and care

The proliferation of privately operated homes, the lack of training on the part of owners and employees, and the profile of clientèles in terms of care needed warrant a questioning of the care and services provided in these settings. What is the situation with regard to the measures taken to ensure access to and quality of care, on the one hand, and those for protecting the most vulnerable residents who are not receiving adequate care, on the other?

2.2.1 Description of the legislative measures provided by the *Act respecting health services and social services*

The *Act respecting health services and social services* grants every citizen the right to receive continuous, personalized services that are adequate from the scientific, human and social standpoints (LSSS, c. S-4.2, s. 5). It should first be explained that this right, and the related obligations, have significance only in the context of the said Act and are binding only on public or licensed institutions. The scope of application of the right to services therefore does not extend to privately operated, unlicensed homes. Unlike in the United States or England, in Quebec there is no specific law governing private lodging facilities.[11] These businesses develop within a system of free competition and freedom to contract and must meet no minimum standard of quality: ratio of caregivers, rules about medication, training of personnel, adaptation of equipment and facilities, and so on.[12] The Ministry and the regional health boards have adopted intervention frameworks that are based on a *bona fide* approach and rely on the good faith of owners to set, through their association, their own quality criteria (RRSSSMC, 1998; RRSSSL, 1998). All policies in effect clearly state that privately operated residential facilities may not lodge people of declining autonomy and must refer these individuals to public institutions in the health system for assessment and possible guidance (MSSS, 1994; RRSSSMC, 1998: 154; RRSSSL, 1998).

The Act even establishes a procedure of supervision and control for verifying whether a privately operated home is carrying on activities for which a permit is required (s. 489). The exercise of this power of inspection, delegated to the regional boards, is based on a complaints and reporting procedure.[13] The Act even

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[11] For an analysis of the American and English legal framework, see in this case: Alexander,E.R.(1997) "Regulation and evaluation criteria for housing for the elderly: an international comparaison" *Journal of housing for the elderly,*12(1-2):147-168, Marek,K.D. (1991) "OBRA'87: has it resulted in better quality of care?" *Journal of gerontological nursing,* 22(10):28-36 and Day,P. et al. *Why regulate? Regulating residential care for the elderly.* The Policy Press, Bristol,1996.

[12] We make an exception here of some fire, food sanitation and building regulations for rental real estate (size of rooms, window arrangement, etc).

[13] For the policy and procedures governing the exercise of this power, see the MSSS-Régies régionales terms of reference. *Les interventions effectuées dans les ressources sans permis en vertu des dispositions de l'article 489 de la Loi sur les services de santé et services sociaux.* MSSS. 1993.

stipulates an exceptional measure for the evacuation and relocation of residents in the case of homes operating without a permit.

> *No person may operate a facility or engage in an activity under a name or corporate name containing the words . . . "residential and long-term care centre" . . . unless he is the holder of a permit issued by the Minister. (s. 437)*
>
> *Where, in a facility, activities for which a permit is required under section 437 are carried on without a permit, the Minister may, after consulting the regional board concerned, proceed with the evacuation and relocation of any persons lodged in that facility, if that is the case. (s. 452)*
>
> *A person authorized in writing by the Minister to make an inspection may at any reasonable time enter any premises in which he has reason to believe that operations or activities for which a permit is required by the Act are carried on. (s. 489)*

It is therefore from the application of the *Act respecting health services and social services* that the expression "clandestine homes" emerges. But to be operating illegally, a privately operated home must not just be providing lodging services; its activities must correspond to those described in the mission of a residential and long-term care centre:

> *The mission of a residential and long-term care centre is to offer, on a temporary or permanent basis, alternative environment, lodging, assistance, support and supervision services (as well as rehabilitation, psychosocial and nursing care and pharmaceutical and medical services) to adults who, by reason of loss of function or psychosocial autonomy can no longer live in their natural environment, despite the support of their families and friends. (s. 83, our parentheses)*

It should be noted that the wording of section 83 corresponds fairly closely to the profile we gave of privately operated homes, their services and clientèles, with the exception of psychosocial and rehabilitation services, which are seldom provided.[14] The Act thus places in a situation of illegality homes that attempt to develop care

[14] We should point out that with the mergers and budget cuts, it is far from evident that the said services are accessible in all public residential institutions.

and services to meet the needs of their clientèle of declining autonomy, and violates the rights and freedoms of residents governed by the relocation measures. Here is fertile ground for analysing the inadequacy of the current measures and their means of application!

2.2.2 Analysis of the application and effects of the measures

The current overall context of intervention is characterized by a denial of the growing role that privately operated homes play in the lodging and provision of services to persons of declining autonomy. There is no direct measure of support and assistance for facilities, no minimum quality standard, but only an *a posteriori* procedure for monitoring whether they encroach on the spheres of jurisdiction of public institutions. This control measure is surprising, particularly as there are not enough public residential facilities to meet the need.[15] The same is true of the homecare provided by LCSCs, to which residents of declining autonomy should theoretically have access (MSSS, 1995).[16] Despite general principles of universality and accessibility of public health services, their exercise is subject to many reservations and conditions that reduce the scope considerably (Molinari, 1996; Lajoie, 1994). There is no doubt that these limitations, set out in section 13 of the *Act respecting health services and social services*, have the effect of depriving many individuals, including seniors housed in the private sector, of access to public services.[17] In this context of scarce public resources, the prohibition against carrying on activities specific to the mission of a residential and long-term care centre, as described in the Act, appears wholly unsatisfactory and anachronistic. When illegality becomes the rule, there is reason to question the legitimacy of the standard. Although the principle that underlies the monitoring

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[15] The minister of Health admits that the situation in residential and long-term care centres, which house some 13,000 seniors, some requiring considerable care, is very difficult and that few new places are being created (April, 1998 :A3). Similarly, the development of so-called alternative facilities, namely, intermediate facilities and family-type lodges, is still modest.

[16] The persons lodged are eligible, however, for services not covered in their lease. As discussed in the previous section, residents seldom agree to sign a lease. The agreements concluded between owners and tenants are generally oral.

[17] As Molinari (1996: 51) points out, the challenge facing the right of access therefore has less to do with its existence than with its application. «L'accès aux soins de santé: réflexion sur les fondements juridiques de l'exclusion» in Lamarche and Bosset(dir) *Les droits de la personne et les enjeux de la médecine moderne.* Les presses de l'Université Laval : 43-57.

authority is open to criticism, its application could have an effect of *a posteriori* control over the quality of care and services provided to individuals of declining autonomy lodged by the private sector. A more in-depth analysis of the measure and its means of application shows that if the legislator's intent was to protect the elderly who receive inadequate care in privately operated homes, the objective has not been achieved.

Considering that a number of residents have cognitive and physical limitations, are often isolated and rather disinclined to complain, the efficacy of a measure which relies on a complaints procedure is immediately questioned. The study of reports of complaints handled by different regional boards proves convincing on this point. For the 1997-1998 year, the regional board of Laurentides received 22 reports, and the Montreal board processed 48 files (RRSSSL, 1998:12; RRSSSMC, 1999:145). These data are all the more surprising considering the number of privately operated facilities, the prevalence of inadequate care, and compared to the 627 complaints against residential and long-term care centres in the Montreal region.[18] If the number of complaints received is an indicator of the quality of services and the level of user satisfaction, then the public lodging sector should be privatized without delay (sic)! Although reliance on the private sector is limited, and little is known about it, the nature and subject of the complaints handled illustrate the scope of certain problem situations. These complaints reveal serious health problems for this vulnerable clientèle. They concern mainly the inadequacy of the services provided (lack of care, incompetence of staff, improper administration of medication), the security of the physical setting (problem of wandering, danger of falling, unclean), the rationing and poor quality of the food, as well as disrespectful attitudes towards residents (intimidation, total absence of activity, isolation, use of restraints, verbal aggression) (RRSSSMC, 1999).

[18] The percentage of residents of declining autonomy and receiving inadequate care is estimated at 15-23%, depending on the size of the privately operated home (Bravo, Charpentier; 1997: 37-38).

It is not only the foundation and efficacy of the measure that pose a problem, but also its mechanisms and means of implementation. Some owners affected by the evacuation measures have, moreover, exercised their right of appeal before the Commission des affaires sociales to contest these measures.[19] The decisions rendered have almost always upheld the Minister's decision to relocate the residents, based on the following two criteria: Are the unlicensed activities carried on and the lodged clientèles consistent with those described by the legislator in the mission of a residential and long-term care centre? The quality of the services provided, the presence of competent staff or the excellent condition of the facilities have not constituted grounds for arguing against the illegality of the unlicensed activities carried on and invalidating the relocation.[20] On reading the rulings, one notes, however, the sensitivity of judges to the plight of the elderly who will be transferred after living several years in the same facility. The tribunal mentions "consequences fairly disastrous to people of this age . . . who are in fact the only ones to be really touched and affected by the Minister's decision" ([1994] C.A.S: 337) [translation]. We identified only one decision that allowed the appeal of a privately operated home in view of the fact that it provided services to persons with certain problems or deficits that were not the exclusive domain of public institutions.[21] "The Minister's authority to relocate must not be isolated, but placed in its context," the tribunal would aptly say, since, if necessary, it could be used to intervene in families lodging a dependent relative (:582). Unfortunately, the opinion expressed would not be repeated in subsequent rulings.

The study of all these institutional documents and judicial decisions reveals a major discrepancy between the regulatory mechanisms and the actual situation of privately operated homes. Two strategies may be adopted. Either the State recognizes the growing role of the private sector in lodging seniors of declining

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[19] See in this case *Services de santé et services sociaux-7* [1994] C.A.S. 330, [1987] C.A.S. 579, [1982] C.A.S. 391, [1982] C.A.S. 388, [1987] C.A.S. 1057.

[20] *Services de santé et services sociaux-7*[1994] C.A.S. 330 and [1982] C.A.S. 388. Conversely, given the two criteria applied, one might wonder whether the court would cancel the transfer of an elderly person of seriously declining autonomy living in a room and board type lodging that provides no care or services.

[21] *Services de santé et services sociaux-7* [1987] C.A.S. 579.

autonomy and establishes measures of assistance and regulation to ensure some control over quality and protection of the most vulnerable, or the State prohibits the lodging of dependent persons in private, unlicensed homes, guarantees compliance, and consequently increases its supply of public services to meet the blatant needs of its ageing population. Our analysis tends to show that the present framework of intervention remains vague. If the latter option seems preferable, it is not applied with conviction and the results are watered down.

The situation might be summarized as follows: In order for seniors of declining autonomy and living in a privately operated residence to have access to the care they require, they must: live within a territory in which the LCSC has the will and staff needed to provide services, be fairly seriously handicapped to be eligible for public lodging, or have sufficient financial resources to afford a home with a good care and services environment . . . and hope this home is not subject to an evacuation order for unlicensed activities! As for their protection against inadequate care and neglect, they will have to rely on that provided in section 48 of the *Charter of Human Rights and Freedoms*.

2.3 Protection against abuse and neglect

This last section thus raises the disturbing question of the abuse and neglect of the elderly. For ten years or so, this problem has occupied an important place in the gerontological research and literature.[22] The particular situation of dependency experienced by elderly residents presents a high degree of risk of domination and exploitation. As we showed in the previous chapter, the home tends to meet several needs of seniors: room and board, daily help with washing, dressing, recreation, and even care (medication, pressure ulcers, etc.). Sometimes, the home will also provide help with shopping and assets management. The step from dependency to dominance (Memmi, 1997: 13) is easy to take, particularly when

[22] The study by Podniecks, E. and Pillemer, K (1990) is a classic, *Une enquête nationale sur les mauvais traitements des personnes âgées au Canada*. Ryerson Polytechnal Institute. See also Montmigny, L.(1998) «Pour mieux connaître et comprendre la problématique des mauvais traitements exercés envers les personnes âgées» *Intervention* 106: 8-19 which presents a review of the literature in this field and several definitional elements of types of neglect and abuse.

the elderly person is weakened by social isolation and loss of physical and cognitive autonomy. This contextualization shows the relevance of describing and analysing the protective measures established to counter the abuse of elderly residents.

2.3.1 Description of the legislative measures provided by the *Charter of Human Rights and Freedoms*

The Canadian and Quebec charters of rights provide added protection for the fundamental rights and freedoms of individuals by explicitly naming them and attaching to them additional guarantees. While the rights granted are for all citizens and apply generally, the Quebec Charter provides special protection for the elderly and handicapped.

> *Every aged person and every handicapped person has a right to protection against any form of exploitation. Such a person also has a right to the protection and security that must be provided to him by his family or the persons acting in their stead.* (s. 48)

This provision assumes its full importance owing to its legislative uniqueness in Quebec as a mechanism of protection for the elderly (Gamache and Milette, 1987: 94). Moreover, the Charter establishes a human rights commission that it empowers to investigate cases of discrimination (s. 10 to 19) and exploitation (s. 48.1). An elderly person or group of elderly persons suffering abuse may thus file a complaint with the Commission and take advantage of its jurisdiction to defend their rights. The request for an investigation may even be filed by "an agency devoted to defending the rights or welfare of the elderly" [translation], without the consent of the victim (s. 74). Pursuant to section 73, the Commission may also conduct an investigation on its own authority, allowing for the denunciation of a case of abuse by an individual not expressly designated by the legislator. In the event the complaint is admissible, the Commission will try to find a settlement through negotiation or arbitration. If its actions prove fruitless, it will propose remedial measures (cessation of the action complained of, restitution, etc.) and finally, it may turn to the Tribunal des droits de la personne in the event there is no

co-operation. We might mention that the Tribunal may, in the case of an unlawful or deliberate infringement of a Charter right, sentence the offender to pay exemplary damages (s. 49). These exceptional damages are designed to punish anti-social behaviour and serve as a deterrent. The Tribunal has already resorted to such measures in cases of the exploitation of seniors living in a residential facility. We therefore propose to analyse the content and application of this special protection.

2.3.2 Analysis of the application and effects of the measures

The wording of the article causes no confusion as to the legislator's intent to include in the protection all types of exploitation: economic, social, moral, physical, psychological or material. Also, the exploiters subject to the Charter may be relatives, employees of public institutions, owners or others. But who are the elderly covered by this measure, and in what circumstances can exploitation be alleged? According to the opinion issued by the Commission des droits de la personne (1983), for there to be exploitation of an elderly or handicapped person within the meaning of the law, three conditions must be present. First of all, the elderly person must suffer harm (deprivation of food, verbal aggression, overmedication or excessive restraint, etc.). Secondly, their advanced age or handicap must affect them physically, mentally or psychologically to the point of placing them in a situation of dependency. Finally, the exploiter must benefit from this situation of dependency. There is no doubt that the criteria required may be applied to the context of both private and public lodging. Moreover, the Tribunal des droits de la personne has heard two deeply moving cases, which we present briefly here.[23]

The Brzozowski (1994) case concerns the economic exploitation of five elderly immigrants of declining autonomy living in a privately operated home. The allegations all mention that the victims were deprived of the ability to manage their

[23] *Commission des droits de la personne c coutu* [1995] R.J.Q. 1628 and *Commission des droits de la personne c Brzozowski* [1995] R.J.Q. 1447.

assets and that the defendant cashed their pension cheques.[24] In one instance, the owner appropriated a sum of $45,000 belonging to one resident. All of the evidence filed in court shows that the owner isolated the residents, even preventing caregivers from meeting with them in complete privacy. Although the owner in question had previously been found guilty of fraud, served a prison term and had to repay the sums, the Tribunal des droits de la personne sentenced her to pay material, "moral" and exemplary damages to the residents totalling $100,000. In 1995, another case of exploitation and violation of the dignity of residents made the newspaper headlines and caused dismay. The owner, Jean Coutu (not to be confused with the pharmacist) was ordered to pay $1.5 million in damages. Violations of the fundamental rights of mentally handicapped residents are legion: forced labour, infantilization, contemptuous, even hateful, language, appropriation of residents' monthly allowance, and so on. We might point out that Mr. Coutu's privately run home had had a contract with the MSSS since 1988 as a "pavilion" and was paid for the services rendered to 90 clients—which goees to show that having a permit is no guarantee of quality![25]

What is particularly striking about these two rulings, given the seriousness of the wrong done, is the time that passed between the first suspicion or observation of offences by caregivers and their cessation. In the Jean Coutu case, the first inspection visit by the Ministry was made nine (9) years before the final ruling! As for the Brzozowski case, heard in 1995, it was in February 1991, after having met with several refusals, that ministerial representatives were able to visit the residence accompanied by interpreters. There was either laxity on the part of caregivers, or an obvious lack of legal instruments for intervening more authoritatively in extreme and urgent cases.

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[24] idem, pp. 1448-1449.

[25] While our analysis concerns specifically the private lodging sector not licensed by the MSSS, we wish to point out that there are also instances of neglect and abuse in the institutional setting. In this case, see Spencer,G. *Les mauvais traitements et la négligence envers les personnes âgées en milieu institutionnel.* Health Canada, 1994.

As we saw in our earlier analyses, it is not enough to establish rights and attach to them application mechanisms (even beyond judicial control); the people concerned must also exercise those rights. For there to be an investigation, there must be a complaint. Of all the investigations conducted by the Commission, those pertaining to the exploitation of seniors are quite rare, if not marginal.[26] Obviously, given the dependency of elderly residents in a situation of abuse, their fear of reprisals, they find it nearly impossible to appeal to the Commission. As for the caregivers or close relations who witness such situations, the Quebec Charter authorizes them to file a complaint, but does not oblige them to do so.[27] We would point out that some Canadian provinces have adopted laws that oblige professionals and other caregivers to report cases of the abuse or neglect of dependent adults. The opponents of such a measure maintain that it discriminates against the elderly and violates their individual freedoms.[28] They also feel that seniors, knowing that professionals are obliged to file such a report, would be more reluctant to consult them and seek help.

In our view, the discussion is far from over. In the current context in which responsibility for the elderly and for dependent adults increasingly rests with the family and the private sector, the issue deserves to be revived. It is not a question here of promoting a specific law for the protection of seniors such as exists for the protection of youth, but of strengthening existing mechanisms for the oldest, most dependent adults.[29] Should it become mandatory to report any form of exploitation of the elderly and handicapped covered by section 48 of the *Charter of Human Rights and Freedoms*?

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[26] For example, in 1995, of the 1,932 complaints allowed as falling within the Commission's jurisdiction, only 11 involved cases of exploitation (Rapport annuel 1995:29-30). In 1996, of the 2,036 complaints and 883 investigation files opened, 29 concerned cases of exploitation (Rapport annuel 1996:31-32).

[27] In the context of our teaching functions in geronotology and social services, we are in a position to note the extent to which caregivers and health and social service professionals are unaware of the existence of this recourse to the Commission des droits de la personne.

[28] This opinion is that of the Comité sur les abus exercés à l'endroit des personnes âgées *Vieillir...en toute liberté*, MSSS, Québec, 1989.

[29] In this regard, see GARON, M. *Quelques notes en marge de la consultation du Conseil des aînés sur : l'opportunité d'une loi sur la protection des aînés*. Commission des droits de la personne et des droits de la jeunesse. 1995.

3. DISCUSSION OF THE CONSISTENCY BETWEEN THE VALUES PROMOTED AND THE ACTUAL LEGAL FRAMEWORK

This last chapter presents the views of the stakeholders regarding the adequacy of the measures governing privately operated homes. As mentioned in the introduction, the methodology used is that of the focus group; managers and caregivers in the public health and social services system participated in separate groups. As the research project as a whole, including the submission of the final report, extended over six months, we were not able to organize a focus group with seniors living in different privately operated residential facilities. We will present, however, the positions of Quebec seniors' associations, mainly that of the FADOQ (Quebec Federation of Senior Citizens) and the AQDR (Association pour la défense des droits des retraités).

For the two focus groups, each invited participant received in advance a written invitation together with an interview outline describing the topics of discussion. The first point for discussion was the relationships of dependency experienced by elderly residents of privately operated homes; the participants were asked to share their perception of the level of vulnerability of residents (cognitive and functional, economic and psychosocial). The second topic concerned the values and principles to be ranked in order of importance in the development of private lodging: freedom of choice, quality and security of the living environment, access to health care and services, and protection against abuse and neglect. Finally, the participants were questioned about the adequacy of the current framework, that is, whether the current measures guarantee respect for the values and principles deemed most important. The reader will find appended to this report a model letter and the interview outline. We would point out that each session lasted about two and a half hours, and was recorded so that detailed minutes could be produced later. Following is a summary of the exchanges, with emphasis on the main points of consensus.

3.1 The view of managers and caregivers in the health and social services system

The dependency of elderly residents

First of all, caregivers and managers in the health and social services system observe an ageing and growing dependency of the elderly clientèle living in privately operated homes, a phenomenon they associate mainly with the fewer number of beds in the public sector. They recognize, moreover, that the first- and second-line public system (LCSC, short-term hospitals and geriatric units) are steering seniors presenting with minor to moderate cognitive and functional impairments to the private sector. They also notice that residents, relatively autonomous at the time of admission, gradually, or sometimes suddenly, lose their faculties. Caregivers are concerned about the fact that some privately run facilities, despite their good intentions, do not perceive the problems related to the declining autonomy of their residents and do not always refer the most serious cases to the public sector. The elderly clientèle living in privately operated homes therefore strike them as dependent in terms of their health, especially at the cognitive level.

With regard to the financial vulnerability of elderly residents, they note discrepancies in the charges for basic services and question, above all, the absence of rules related to billing for additional services: distribution of drugs, bathing assistance, and so on. Now, in the present social climate, the participants note that the financial position of a large number of seniors is unstable. They are worried that these less affluent residents cannot afford to pay for services or choose a privately operated home that provides more services. Caregivers say they are therefore very concerned about the question of equity.

The question of the emotional dependency of residents on homes is a very delicate one, according to caregivers. They recognize that close bonds are formed between managers and their residents, particularly in small establishments. Some mention a mutual attachment that makes it very difficult to relocate the resident

when another setting would better meet their service needs. This attachment tends to cloud the manager's and resident's perception of deficits and of the extent of the services required. There is a grey area where different values can come into conflict: the quality of the interpersonal relationships, the security of the resident, the availability of services and care, and so on.

All recognize that residents are more dependent when a loss of physical and cognitive autonomy is compounded by the factors of economic and social vulnerability, even isolation.

The values and principles deemed most important

It emerged from the focus group of health system caregivers that access to care and the quality of the services provided are the essential principles that should govern the development of the private lodging sector. They wish to point out that their concern about the quality of care and services also extends to the current situation that prevails in the public lodging sector. Specifically with regard to privately operated homes, while they distinguish between the most structured facilities and those that spring up spontaneously or in an almost *ad hoc* manner, the stakeholders consulted noted a flagrant lack of training and preparation on the part of owners, who do not understand that not just anyone can improvise and open a residential facility with a minimum of qualifications. As one of them pointed out, garage owners need to have a trade certificate, hairdressers take courses, and you have to have a permit to hold a garage sale. He found "this laxness on the part of society" about the qualifications of owners and their staff all the more difficult to understand given that the clientèle served is elderly, vulnerable and of declining functionality.

The discussion then turned to the role of the State and the lack of support provided to privately operated homes for meeting the needs of their clientèle of declining autonomy. This shortcoming seems more pronounced where the needs of cognitively impaired residents are concerned. Caregivers feel that the public

system is better structured to provide medical follow-up: regular presence of a physician in some homes, nursing or attendant service from the LCSC for care and post-operative follow-up. As for the loss of cognitive autonomy of elderly residents, they note that the response of the health system is far less organized and the lack of knowledge on the part of managers is especially pronounced. Homes have few staff members familiar with the different types of dementia, they note.

The freedom to choose one's dwelling, as exercised by seniors, did not emerge as a top priority in the current context. Caregivers do not feel strongly about it and point out that in fact, freedom of choice is contingent upon knowledge of existing resources and, especially, the financial capacity of the residents. The social workers present noted that the elderly and their families are isolated in their decision and do not always have the capacity to choose. Some caregivers guide people through the decision-making process and the choice of a living environment, suggesting two or three homes that appear best suited to the individual's needs, while others claim they are uneasy making referrals others to the private sector or that there is a definite conflict of interest.

The problem of the abuse and neglect of residents was discussed at length. Some participants are especially concerned about it and see the need to strengthen the protective mechanisms, while others feel that cases of abuse remain marginal. Caregivers concur in identifying certain risk factors: the isolation of facilities, the burnout of managers, and financial difficulties. Small homes where there are few or no staff to share the duties and pressure are at greater risk of being overwhelmed and of developing negligent or abusive behaviours. It is recognized, however, that there are also abusive practices in the large public institutions: overuse of restraints, fewer baths and diaper changes, and so on.

The adequacy of the current measures

All the participants recognize that the State has a role to play and a responsibility to assume with regard to the elderly experiencing declining autonomy and living in privately operated homes. In their view, the development of the private lodging sector and the increase in the number of clientèles are the consequences of fewer beds and the trend towards more ambulatory care, which have come about too quickly and without sufficient planning. They feel that the government cannot give up all responsibility and place the burden on the backs of families and the private sector. According to the managers and caregivers consulted, seniors who are losing their autonomy and living in privately operated homes must be granted the same entitlement to services.

The comments tend to show that the current framework is not adequate and does not correspond to the reality. The present system is proving contradictory in several respects, according to one participant. "If we consider the overall situation from the legal standpoint, there's no getting around it. On the one hand, we tell the privately operated homes that they don't have the right to lodge people of declining autonomy, but we refer more and more serious cases to them; on the other hand, we consider them to be a home." We are thus faced with a situation in which some LCSCs provide home support services to residents of declining autonomy in a privately operated home, while others do not, or on different conditions (size of the home, type of services required, etc.). People are worried; privately operated homes, especially the small ones, are more and more overburdened, have little respite and are having profitability problems. But as one participant explained, if it is formally acknowledged that privately run, unlicensed homes lodge seniors of declining autonomy, this implies that they must be funded; otherwise, only the most affluent residents will have access to the care and services. The question of equity crops up again in the debate.

It seems essential, then, for caregivers to support homes and forge more links between the public and private sectors. They note, moreover, that many initiatives are emerging from the "current legal vagueness." They tell of various experiments underway, including the ministerial plan to buy places in residential facilities and various forms of regional agreements.[30] While in favour of new creative approaches, they recognize the need to set minimum standards and establish provincial guidelines, for example, through an umbrella program. According to some, the development of new lodging resources entails different classes of licensing or accreditation and various funding models. All feel that increased penetration of private facilities would reduce the risk of neglect and abuse.

Concerning the question of the inadequate care and neglect of elderly residents of declining autonomy, the caregivers told of major flaws in the system for filing complaints with regional health and social services boards. First of all, residents and their close relations, as well as stakeholders in the system, have little experience with this recourse and hesitate to report problem cases. They also note that corrective action is taken only if the owner of the home in question co-operates, and is voluntary. One caregiver also pointed out that as the complaints procedure was confidential, it is not possible to know which homes provide inadequate care; hence the risk of continuing to refer seniors to them. Although cases of serious abuse are still, in their view, the exception, some perceive the need to rethink the protective mechanisms. One participant again brought up for debate the need for a law to protect the elderly, which had been ruled out because of its infantilizing nature. He noted, moreover, a shift in thinking over the past year in favour of a protective law aimed specifically at individuals of declining autonomy—class legislation that would guarantee them rights, including the right to health services and social services. The other participants seemed to

[30] In this regard, we refer the reader to a recent analysis of various forms of private-public partnership related to lodging. See Charpentier, M. et al. *Analyse du projet pilote ministériel d'achat de places d'hébergement pour les personnes âgées en perte d'autonomie et de certaines formules régionales.* Direction de la recherche et de l'évaluation, Ministère de la Santé et des Services Sociaux, Québec,1999.

acknowledge the relevance of putting such issues back on the political and legislative agenda.

3.2 The view of the owners of privately operated homes

To take into account the reality experienced by the owners of privately operated homes of different sizes, we invited to the focus group three managers of residential facilities lodging fewer than 9 residents, two managers of medium-sized facilities (10 to 49 residents) and one owner of three homes having over 50 elderly residents. We also approached an owner of a private placement agency who guides and orients seniors in choosing a private residence. Of the seven people invited, three did not participate in the session. Two of the three owners of small homes were unable to find a replacement to supervise and provide services to their residents, and one of the two owners of medium-sized facilities informed us of a timetable conflict. The points reported therefore constitute a summary of the comments by four entrepreneurs who operate privately run facilities of different sizes.

The dependency of elderly residents

The owners of the privately operated homes note that their clientèle has changed considerably over the last five years and that the level of autonomy of the elderly people they are lodging is declining. For example, one owner told of the case of one woman, a tenant for ten years, who is very attached to her home, but now needs more than four hours of care a day. They agree that their clientèle is increasingly made up of seniors having cognitive deficits and sometimes presenting psychiatric profiles. They note that, whereas several years ago the agreements were made directly with the elderly residents, they now work primarily with the family: in three-quarters (3/4) of the cases, according to the estimate of one. So it is the family, particularly the children, who look after finding a privately operated home when the elderly parent can no longer remain at home or return

there following a stay in hospital. The owners say they are aware of the growing dependency of their residents related to their physical and cognitive health.

As for financial dependency, the owners report complex, and sometimes ambiguous, situations related to the financial means of their residents and the management of their assets. The owner of the private placement agency sees in her practice that many people cannot afford what they want. She also notes quite a disparity in costs from one home to another, even for comparable services. While the owners sometimes lose a resident for financial reasons, it is increasingly common for the children to make up the difference. The signing of leases seems rather theoretical. According to the owners, people are reluctant to commit themselves and sign for twelve months. They themselves have sometimes torn up a lease. As one of them remarked: "lease or no lease, when you aren't happy somewhere..." The delicate subject of managing the assets of elderly residents, particularly those grappling with cognitive deficits, was broached. The owners must deal with large grey areas: unfit residents rarely have legal representation and do not always have a preauthorized payment plan. In some cases, they note that the family member who is helping the resident does not always seem to act in the resident's interest. The owners observe that monthly visits from children fall on the date old age pension are paid out or that the children do not buy the personal effects necessary for the well-being of their elderly parent. The financial exploitation of seniors by their children is a concern of the owners; one participant claimed to have already reported cases to the social worker in his territory. Residents sometimes ask the owner to manage their assets because they are losing their autonomy and are insecure, their family is far away or they do not trust their children. Two owners present said they categorically refuse to become involved in managing the assets of their residents, even if the residents ask them to. This refusal does not rule out, in everyday life, the possibility of doing some errands for residents, such as making a bank deposit. One participant told of the case of a longstanding resident who wanted to give her power of attorney because

her only daughter lived abroad. "I explained to her that I couldn't agree to look after her affairs, and she wouldn't talk to me for months afterward."

This anecdote illustrates not only the attachment and trust some residents have towards the owner of their residence, but their psychosocial dependency as well. One participant pointed out that this dependency can also be expressed as fear of the owners. This fear seems more present when the senior is thinking of leaving the home. The representative of the placement agency noted that the elderly are vulnerable to pressures and "perceive exchanges and discussions with the owner as a kind of harassment." They want to point out that the loss of a client does not have the same impact on a small operation with 4 residents that it does on one with more than 50. The discussions also revealed the considerable psychological and decision-making dependency of residents on their children. According to the owners, the situation is especially difficult when there is dissent within the family: one child is prepared to pay more so that the increasingly needy father or mother can have more services and remain where they are, while the others favour placement in the public system (sometimes in order to pay less when the elderly person has a limited income). According to the owners, some families are very present and involved, while others tend to leave everything up to the home and to neglect their responsibilities, and sometimes even abandon their elder.

The values and principles deemed most important

From the outset, the owners consider all aspects related to the protection of seniors living in privately operated homes to be fundamental. In the current context of growing clientèles, the issue of their access to health and social services is closely tied to that of their protection. The stakeholders we met with discussed at length the issues of access to services and co-operation with the public system. In their view, privately operated homes must be open facilities that do not keep tenants in a vacuum. They claim they are responsible for being honest in identifying the services they are able to provide and their limitations. The owners must now develop skills in seeking outside resources and services, but mastery

and trust of the health system take a long time to develop and are far from self-evident. One of the participants who has worked in the private lodging sector for twelve years maintains that it has only been in the last three years that the co-operation of the public system has been firmly established. Another participant, a new owner for about six months, admits that it is very difficult to find one's way at first: "I still wander from one voice mailbox to the next." Many obstacles were identified. The public resources available for residents of declining autonomy vary from one jurisdiction to another, are inconsistent, and it is very difficult to know the access criteria (for home support provided by LCSCs, for a short-term geriatric assessment, etc.). The owners all acknowledge that when the public system comes to them to place someone and "free up a bed," things move quite quickly, "sometimes the same day." The waiting time is something else again when they are the ones seeking co-operation to relocate a difficult case (such as someone with disruptive behaviour) or to assess a resident and adjust their medication! In their view, there is a flagrant shortage of resources, especially for quick troubleshooting and help with psychiatric cases. Even the search for volunteers can prove difficult. One owner of a small home reported that when she asked for volunteers to make friendly calls to a lonely resident and take another for a walk (which she has no time to do daily), she was told that volunteers would not go to a privately run home. She added, "It's the resident who suffers for it in the end."

The owners do not seem to consider the values of individual freedom, freedom of choice and freedom to contract as having top priority in the context of private lodging. We find this view rather surprising considering that we were questioning stakeholders who invest a lot in a free entreprise system. The participants note that this freedom of seniors is very limited in reality and is exercised through the family. Even when people deal with a private placement agency to help them make their choice, their freedom is limited by what they can afford and to only those homes with which the agency deals.

We also asked the participants about the quality of the private lodging system. What value do they attribute to the quality of the living environment and to the security of the home? The owners attribute a great deal of importance to the reputation of their homes; as one put it, "it's your livelihood." "You provide the services, or you go under." In their view, the law of the marketplace demands that a decent level of quality be maintained. There are also health and building standards to be met, depending on the size of their facility. One participant noted, however, that there are no standards where care and services are concerned. The owner of the placement agency pointed out, moreover, that some homes with 30 tenants have only one employee: "The residents get three meals a day, the laundry gets done, but...." Our participants also discussed the presence of psychosocial activities in homes given the ageing and declining autonomy of the clientèle. They recounted experiences where the level of participation was low: 2 residents out of 18 present at the activities organized by one trainee, 10 out of 50 seniors participating in fitness classes. They say they rely more on simple everyday activities that bring the home to life: taking advantage of the strawberry season to organize refreshments outdoors, celebrating birthdays, and so on. In their view, the strength of the private sector lies in its attempt to recreate a family atmosphere, a more personalized setting.

The adequacy of the current measures

The owners feel that the private sector has evolved a great deal and withstood the major changes that have occurred in the health system. The clientèle has grown considerably and new owners are better informed of the challenges that await them. The participants point out, however, that the law has not been amended and that, as a result, privately operated, unlicensed homes are not always authorized to lodge seniors of declining autonomy. "But everyone knows that's no longer the case," asserted one owner. He added that in the same way, privately operated homes not licensed by the Ministry were once called "clandestine"—a term that evokes a back alley, in his view! According to the participants, the situation is changing. Even the political discourse is beginning to change. The government will

no longer have a choice, they believe; seniors needing three hours of care a day will go to the private sector, and the care required by clientèle of residential and long-term care centres will go up to four hours. "Given everything the private sector is currently doing, all it takes is a little nudge in the right direction" said one participant. He added that it costs over $3,000 a month to lodge someone in the public system, while the government allocates no budget for those lodged in the private sector. Over the last ten years, rent increases, which the owners consider modest, have not been enough to offset the increased needs of residents; hence the large number of homes going bankrupt. Whereas previously the acquisition of a privately operated home was seen as an opportunity to deal in gold, it is better known now that the market is fairly risky. They stressed the lack of resources to assist homes, to ensure access to certain care and services for residents. The owners are of the view that the government ought to help the homes, in particular the residents. Some suggest that the LCSCs should have a special budget for homes, that a social worker be assigned to each home. Others feel that the resident clientèles should be monitored; all residents could be visited annually. Such measures would ensure residents of better protection.

As for the imposition of quality standards or requirements for privately operated homes (besides those that apply to the building), some participants say they are open to a form of accreditation of homes or licensing to operate. One owner is of the opinion that these mechanisms must fall under a government structure and be provincewide. None of the participants perceives a need for qualification or training requirements for owners. They say that "the law of the marketplace forces them to learn fast and to seek out partners." It is their view that if owners are good and know how to surround themselves with the right people, they will gain a clientèle, and "there is no need for a diploma or course to provide client services."

3.3 The view of senior citizens' associations

Where do senior citizens' associations fit in this context in which the unlicensed private sector is the main lodging resource in Quebec? How do they define the

place and role of seniors and their families, the State and the commercial lodging sector?

In an article entitled *L'évolution des services de santé et des services sociaux: la réaction des groupes d'aînés québécois* (the evolution of health and social services: the response of Quebec seniors' associations), Sévigny and Hurtubise (1997) analyse the positions and arguments of seniors' associations based on submissions filed at various parliamentary commissions and public hearings. Their study shows that Quebec associations feel that the State must play a central role in meeting the needs of the elderly. The briefs studied state the importance of autonomy for the elderly and their desire to remain in their own home for as long as possible. The associations are concerned, however, that in the present context of cutbacks in public services and budget reductions, the elderly will be kept prisoners "within their walls" so that they do not cost society too much.

As for the place in the private for-profit lodging sector, as early as 1979 in its "Manifeste vieillir chez soi" (Manifesto: ageing at home), the AQDR took a clear stand against this solution, exposing the risks of abuse and neglect (Sévigny and Hurtubise,1997:131). Anglophone associations, including the NAG Senior Citizens Council, proved more open to the development of privately run homes for the aged. They recommended that the Rochon Commission not ignore the private sector, but deemed it essential to set standards to avoid creating a dual system: one for the poor, and another for the rich. After analysing all the documents produced by the various associations, the authors of the article conclude:

> [Translation]
>
> [N]o group supports the neo-liberal vision that relies on the laws of the marketplace to regulate social relationships. Seniors' associations rely primarily on the intervention of the State and on the strength of the community. (1997: 141)

Concerned about the absence of State intervention in the matter of privately operated homes for the aged, the FADOQ introduced a program of voluntary

accreditation called "Rose d'Or" (gold rose). The purpose of this pilot project is to evaluate the homes within a territory using an index rating and award them one or two gold roses, depending on the rating they are given. The results would be made public in a reference booklet, and could guide seniors who are looking for a home that meets certain quality criteria. Tried in three regions of Quebec, this innovative project attempts to fill a large void. But it is encountering major obstacles.

First of all, the voluntary nature of the participation of homes and the lack of financial support to extend the project throughout Quebec greatly limit its impact. Also, the ratings can quite often be affected by the many changes undergone by privately operated facilities (new owner, staff changes, change in the number of places, etc). Finally, one of the criticisms most often made by caregivers in the health and social services system is that the rating of homes does not take into account the needs of the elderly residents of declining autonomy who live in these settings. If we recognize that the quality of the care and services provided to the elderly of declining autonomy living in privately operated homes is an extremely important issue, there is reason to question whether it is up to the FADOQ to make the evaluation. This question raises that of the mission, competence and, above all, enablement of an agency to evaluate and control the quality of care and services. We ourselves believe that the FADOQ is worthy by virtue of having initiated a pilot project and shown a certain wisdom by limiting its sphere of activity.

CONCLUSION

The debates surrounding the evolution of health and social services are currently dominated by the spectre of privatization. Some quarters are concerned about the advent of two-tiered medicine and the growing number of private homecare agencies. The lodging of seniors is one of the sectors where the greatest transfer from the public to the private sector is taking place. This trend towards privatization, well underway as we have shown, raises important social and ethical issues about the quality of and access to care for elderly residents and the protection of the most vulnerable among them. The current system, based on free entreprise and the freedom to contract, maintains and even intensifies the inequalities that already exist, to the point of depriving the most needy of the services their condition requires. Our comments are not directed at the legitimacy of privately operated homes, but rather the redefinition of the role of the State, of its role as regulator (Day, 1996).

The analysis of the legal mechanisms in place reveals major shortcomings. Not only does the current legislative and institutional framework seem vague and inadequate; it does not even recognize (at least formally) the dominant place occupied by the unlicensed private sector and its expanded role for the very elderly of declining autonomy. The control of privately operated homes that carry on activities for which a permit is required is causing adversity and not at all helping to improve overall services. Even worse, it is the elderly residents who are subject to the evacuation and relocation measures. The owners of the homes in question need merely recruit new clientèles and continue their activities. As for the protective measures, the data presented eloquently show that the means of application considerably limit their efficacy. The views of the stakeholders consulted tend to support this and revive the need to review the current legal protections, taking into account the dependency of the elderly, particularly those who are cognitively impaired.

The reader will surely wonder about the direction to be given future social policies. What model of regulation and intervention should be given preference in view of the problem generally, and specifically the vulnerability of the elderly residents concerned? We agree with the comments of Johnson et al. (1998:310): "All regulatory systems are to some extent dependent on trust. Evaluation, monitoring and inspection are time-consuming and costly and complete policing is undesirable." The solution therefore does not lie through strict regulation; this would impose too heavy a burden on privately operated homes, particularly small- and medium-sized ones, and could compromise their existence and survival. The mandatory registration of all homes seems to us a first essential step, a view shared by the persons consulted in the context of this study. Though some municipalities require a permit to operate, no mechanism is in place to monitor the volatility of these facilities. The enactment of minimum standards and basic requirements, together with an annual inspection of all homes, is one major avenue to explore. The procedure should be based on the discretionary powers of a regional or local government authority linked to the health system. It seems essential, in our view and that of the stakeholders we met, to develop links between the public health system and the private lodging sector and to provide mechanisms for co-operation and dialogue.

But the main issue remains, undeniably, the use of public funds to support people living in the private sector who are physically, financially and socially dependent. Obviously, the allocation of public funds implies different forms of control over spending: eligibility criteria, screening of clientèles, and so on. Such controls are legitimate if their aim is not to reduce the supply of and demand for assistance, but rather to ensure greater equity.

It appears that the vulnerability of seniors living in privately operated homes is not attributable solely to their frailty from the health, social and economic standpoints and to their considerable difficulty in gaining respect for their rights. More

fundamentally, it is linked to the lack of political will concerning the mechanisms needed to protect them against abuse and guarantee them access to a quality living environment in which the care and services required by their condition are available. It is our humble hope that we have fuelled the debate surrounding the development of privately operated homes for the aged and shown the relevance of recognizing and better defining, even regulating, the role of this important social force. Our objective will have been met if we have helped put these new issues on the social policy agenda. We wish, moreover, to thank the Law Commission of Canada for the interest expressed in this subject of study.

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